Print, fill out and return to Risk Management

NWCC Form 1
Revised 03-02

Nebraska Workers' Compensation Court

First Report of Alleged Occupational Injury or Illness

Employer

Employer **FEIN 47-6006256** UI# **0160266007** SIC Code # **91313**

Employer Name(s) **City of Lincoln**
Address **233 South 10th Street, Rm 210**
City **Lincoln**
State **NE** Zip Code **68508** Phone **402-441-7671**

Insured Name *(If different from employer name)*
City of Lincoln, c/o Risk Management Division
555 South 10th Street
Lincoln, NE 68508

Insured Address *(If different)*
Dept. Div
Location

Insurance Carrier

Carrier FEIN **47-60006256**

Administrator FEIN **58-0506554**

Employer Name(s) **City of Lincoln - Self Insured**
Address **c/o Risk Management Division**
233 South 10th Street, Rm 210
City **Lincoln**
State **NE** Zip Code **68508** Phone **402-441-7671**
Policy Number **n/a**
Policy Period: From **n/a** To **n/a**
Insurance Carrier/Self-Insured Code # **SI-043**

Claim Administrator ***(Name, address & phone number)***
City of Lincoln
Risk Management Division
233 South 10th Street, Rm 210
Lincoln, NE 68508
P - 402-441-7671, F - 402-441-6800

Self-Insured ☒ *Check if Appropriate*
Carrier/Claim
Claim Administrator Claim #
Jurisdiction Claim#

Insured Report #
Jurisdiction **NE**

Employee

Name *(last, first middle)* _____
Address _____
City _____
State **NE** Zip Code _____ Phone **402** _____

Full Pay for DOI Yes ❑ No ❑
Salary Continued Yes ❑ No ❑

Number of Days Worked Per Week ___

Sex Male ❑ Female ❑

Number of Dependents _____

Occupational Job Title

Marital Status
Married ❑
Separated ❑
Unmarried ❑
Unknown ❑

Wages $
Hourly ❑
Daily ❑
Weekly ❑
Bi-Weekly ❑
Monthly ❑

Occupational Code

Date Employee Began Work-Related Duties

Employment Status FT ❑ PT ❑ Other ❑

Date of Birth | Social Security Number | Date Hired

Occurence/Treatment

Date of Injury/Illness

Time Employee Began Work AM ❑ PM ❑

Time of Occurrence (Cannot be determined ❑) AM ❑ PM ❑

Last Work Day

Where Did Injury/Illness Occur? County State Zip

Did Injury/Illness Occur On Employer's Premises? Yes ❑ No ❑

Date Employer Notified | Date Disability Began | Date Returned to Work | If Fatal, Give Date of Death

Type of Injury/Illness *(Briefly describe the nature of the injury; e.g. lacerations to forearm)* | Nature of Injury Code

Part of Body Affected *(Indicate the part of the body affected by the injury/illness; e.g. right forearm, lower back; and how it was affected)* | Part of Body Code

How Injury/Illness Occurred *(Describe activity and tools, materials, equipment the employee was using; how injury occurred.)* | Cause of Injury Code

Initial Treatment: No medical treatment ❑ First Aid by employer ❑ Minor Clinic/hospital ❑ Emergency Room ❑
Hospitalization overnight ❑ Hospitalized > 24 hours ❑ Future major medical/lost time ❑

Date Administrator Notified | Form Preparer's Name, Title and Phone | Date Prepared